will refer to Lambert's article in the Journal of the A. M. A. for September 29th, on the work he has done in the Bellevue Hospital, the city hospital of New York, on chronic alcoholics and people addicted to the drug habit. He has used the Town method there with the greatest success in ridding the hospital of most of the chronic alcoholic rounders. The method has been tried here a good many times and has been most effective. Unless you begin at the bottom you can not justify the existence of state institutions which are dependent upon organized municipal work for their greatest effectiveness and they should never be thought of as relieving the municipality of its responsibility. I believe that the insane asylums should be rid of the alcoholics because of the fact that once a man has been an inmate of an insane asylum, no matter for what cause, it is only too easy for him to escape punishment at a future date for any crime he may commit.

Dr. W. F. Snow, Sacramento: I have no specific thing to say except that in connection with the public health work I am constantly brought in touch with the need which has been expressed by the various speakers discussing this paper. On the other hand, in coming in contact with the various public or philanthropic bodies I constantly see that there is the uniform idea that we should do such a thing, but no one has brought forward a specific way in which the matter can be taken hold of. I think this paper looks toward some definite legislation, and the words of Dr. Hatch suggest that we should interest a number of our coming legislators to investigate this movement if we desire to have certain bills presented to the legislature looking toward a state institution. It is most probable that the Tuberculosis Committee will bring forward some revised bills and we will have two petitions for state institutions. We must decide in what order we are to advance these bills. I think the public health and philanthropic societies are looking to us as a medical organization to know how we stand. Are these institutions to be on the same basis, so far as administrative control is concerned? Of course, none of these things are far enough advanced for an expression of opinion at the present time, but as physicians we should re-read these papers as they are printed in the Journal with their discussions—and I hope these particular papers will be printed early—and we should talk them over with our friends and be prepared by next November to express our convictions as to whether executive action should be taken during the next winter.

PROLONGED DILATATION FOR DYSMENORRHEA.*

By GEORGE B. SOMERS, M. D., San Francisco.

The discomforts attending the physiological process of menstruation are bad enough, but when there is added an excruciating pain, lasting sometimes several days, occurring, not occasionally, but repeated month after month, as often as the flow recurs, and always looming up prospectively as something to be met and suffered, it is not to be wondered at that the victim finally rebels and begs for relief.

Where the condition is so severe that extreme measures seem indicated, the advice is usually given that the patient submit to a dilatation and curetment. When we consider what this procedure entails, the discomfort, expense and local injury, we ought, at least, to be fortified by the assurance that the measure will be successful. As a matter of fact, the results are often disappointing. In many cases where the advice is given that a dilatation be done, we are met with the reply, "But I have already had the operation and am just as bad as ever." My own opinion is that the cause of failure to get results in many cases is incomplete or insufficient dilatation.

Presuming of course that the operation has been performed in properly selected cases, in other words, in cases where the causes are strictly uterine, dilatation would seem a rational procedure. It is a matter of common observation that marriage alone will often cure dysmenorrhea, and even the severest forms are cured by pregnancy. Furthermore, experience shows that where the operation has been thoroughly done, the results are generally successful.

It cannot be denied that failure is often due to mistaken diagnosis. Dysmenorrhea is not a disease in itself, but merely a symptom. The causes are many, and it is often difficult to locate the condition responsible for the pain. When we consider that all the organs contained in the true pelvis are more or less involved in the menstrual congestion, and that psychic and reflex changes often take place in distant organs, it will be realized that the diagnosis of the cause of dysmenorrhea is by no means simple.

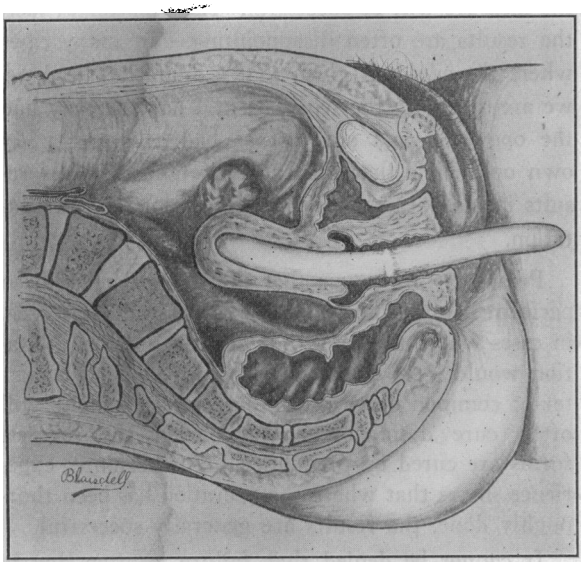
While I do not wish to take up a general consideration of the subject, it will, nevertheless, aid in differentiating those causes suited to mechanical treatment, if we say a word about causes.

Monthly pain may be due to uterine or extra-uterine causes. Extra-uterine causes involve tube, ovary, peritoneum or cellular tissue and are in the great majority of cases inflammatory in origin. Adhesions, exudates and accumulations of pus are common. Such cases are often of a serious nature, and may require a laparotomy for cure. Dysmenorrhea in such cases is clearly only a symptom and the cause is often easily found. Strictly uterine causes are often not easily demonstrated. Pain may be present though the physical examination reveal nothing palpably abnormal.

Uterine dysmenorrhea is more common than extra-uterine, but as a rule is not so serious. Uterine pain is caused by muscular contraction. Among the conditions which produce these contractions may be enumerated the presence of fibroids or polypoids, endometritis, metritis, mal positions and mal development.

The presence of a fibroid or polypoid as a cause of pain is easily understood. Not only does the uterus attempt to get rid of it as a foreign body, but the accompanying clots act as mechanical obstructions in the canal. Dilatation and curetment cannot be considered curative in these cases. Curet-

* Read before the Cooper College Science Club.



The Dilator Should Remain in Place from Eight to Twelve Hours

ment is often a means of relief, but, as a rule, nothing will cure except the removal of the fibroid.

Metritis and endometritis require no particular consideration, since the mere presence of an inflammation is cause enough for pain. But it may be said that these conditions are often distinctly present without dysmenorrhea. These conditions are amenable to simple dilatation and curetment.

The above uterine and extra-uterine causes I have mentioned in order to exclude them from consideration, where thorough dilatation is contemplated.

By far the greatest number of cases of dysmenorrhea are due either to maldevelopment or malposition of the uterus, and the point I wish to make concerns these alone.

In malposition the flexion of the uterus, either forward or backward, produces a narrowing of the uterine canal at the internal os. When the menstrual decidua and blood are shed, they find an obstacle to their free exit. Retention and coagulation are followed by bearing down pain.

In maldevelopment the pain arises from a different cause. It is due to the resistance which the undeveloped tissue offers to the hyperemia of menstruation. In a normal uterus this tissue yields readily, since the organ is erectile and should absorb blood like a sponge. When small and undeveloped it cannot swell and the vascular tension produces pain by compression of the nerve endings.

Whether the condition be maldevelopment or mal position, the indications for treatment are the same—viz., thorough dilatation. By this we expect to attain (1) permanent widening of the canal; (2) thorough stretching of the muscular tissue of the uterus, which in turn (3) overcomes muscular spasm and (4) loosens up the tissues so that they may swell more easily at menstruation.

Technic. The best instruments for attaining full dilatation are the Kelly dilators, consisting of a set of eight short graduated sounds. The process of dilatation should take from three-quarters of an hour to an hour, with the patient fully anesthetized. Not only should the dilatation be slowly and carefully done, but the most important point is, that after size 17 or 18 has been reached, the instrument should be left in place. The patient is put to bed with the dilator still within the uterus. When the patient recovers from the anesthetic, if much pain is complained of, a hypodermic of morphin is given. At the end of eight or ten hours the instrument is removed, by inserting a finger in the vagina against the cervix and then withdrawing the sound.

The result of this prolonged stretching is the attainment of the desired end. The first two or three periods following, are generally accompanied by a very free flow, but without pain. Gradually the flow becomes normal in amount and character.

THE ETHICAL VERSUS THE COMMERCIAL SIDE OF MEDICAL PRACTICE—WHICH WILL WE SERVE?*

By JOHN McMAHON, M. D., San Jose.

An inducement to ask your attention to this subject is stimulated by the reading of an editorial in last month's number of our STATE JOURNAL OF MEDICINE, which, as a preface, I shall here quote for the benefit of the many in our profession who are so pressed for time by their exigencies in the hasty pursuit of the nimble sixpence as to ill afford an opportunity for reading such monthly literature of their professional household.

Our Fees.

"Altruism is a good thing, and it is the actuating principle of our profession; but a certain amount of altruism is due the home and the individual. In this state medical fees have always been somewhat better than in other parts of the country; but we are feeling the contract business and it is a menace. True, in many places there are men who are constantly cutting fees; but they generally get what their services are worth if they get anything. McCormack has well pointed out that there are a good many physicians in this country who are absolutely incompetent; they were turned out by the thousands before there was any state board control; in fact, it was this very thing that brought about state boards of medical examiners. In the long run, it is the patient who suffers from these cutters of fees, for the patient gets just about what he pays for. If he gets his medical attention from a lodge doctor at the rate of about 10 cents a visit, he is getting just about 10 cents' worth; and the doctor is getting full pay for poor services. It is up to us to let the people understand these things; it is up to us to make our county medical societies places of, and for medical instruction—and to let the people know that it pays them, in good services rendered, to support their physicians so that they may receive from them the best up-to-date treatment—which is an

* Read before the Santa Clara County Medical Society, March 17, 1909.